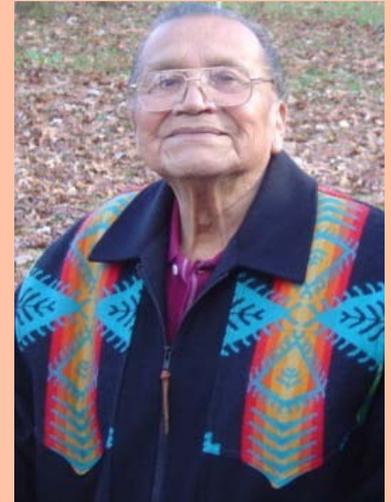


Developing a National Capacity Building Network for American Indian, Alaska Native and Native Hawaiians

**Rapid City, South Dakota
June, 2010**



Many Tribes, Many Cultures...



Facts

- Demographics
 - 560+ federally recognized tribes
 - 2.4 mil classify themselves as AI/AN
 - 4.9 million classify themselves as AI/AN alone or mixed
 - 65% to 70% Natives live off reservation but are still members of sovereign nations
 - We live in reservations, pueblos, villages, rancherias, rural areas and urban areas
- Age- population is younger than general pop
 - 33% under age 18 vs. 26% all races
 - Median age 29 yrs v. 35 yrs all races



Facts

Education- level lower than national average

14% had a bachelor's degree

History- of colonization (traumas)

Boarding school

Loss of land and language

Gender

Includes multiple genders besides male/female

Social structure

Matrilineal, patrilineal, clans, kinships extended family structures



Violence

Violence-domestic, child sexual, rape

- Violent crime among Native women
 - 86 per 1,000 versus 35 per 1,000 (all races)
 - highest among all female ethnic categories
- Sexual Assault
 - Native Alaska women overrepresented in AK
 - (Caucasian 1.28 per 1,000 & AN 8.86 per 1,000)
 - Rape/sexual assault
 - (5 per 1,000 ages 12 or older) compared to all races (2 per 1,000)



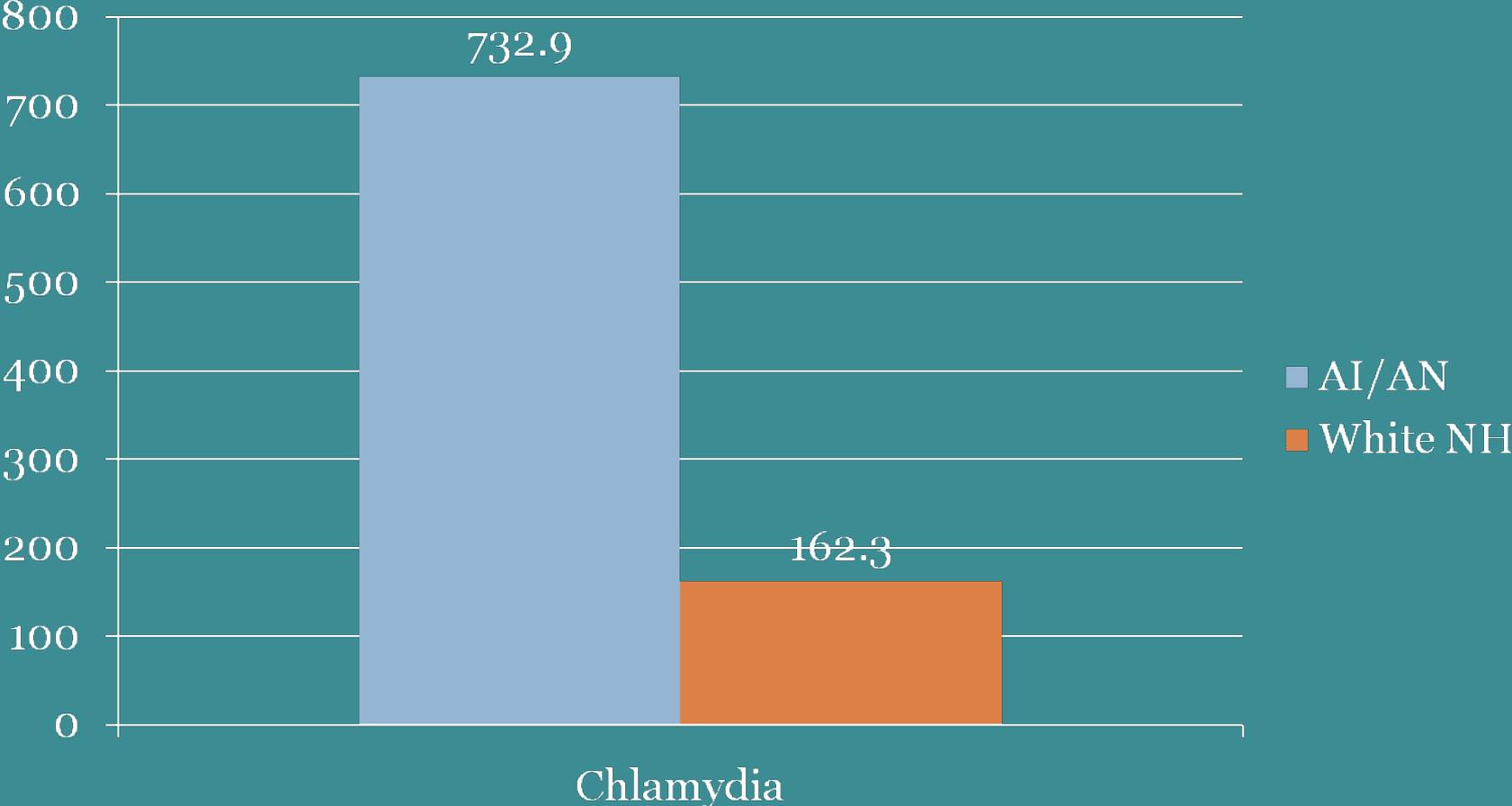
Biological risk factors

Native Specific Risk---High STD Rates

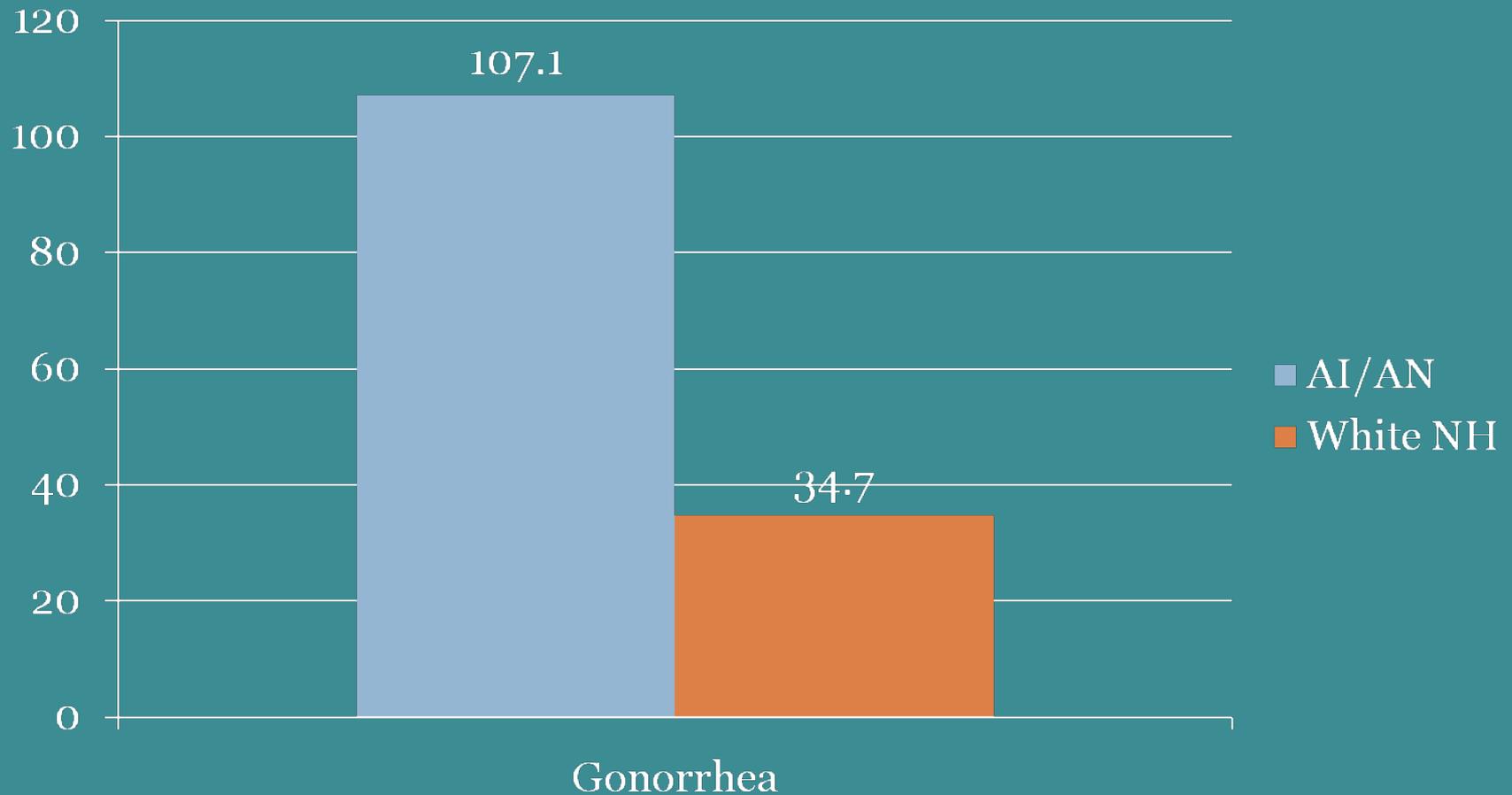
- Disproportionately affected by STDS
- Reported rates of Chlamydia, Gonorrhea, and Syphilis were 2-6 times higher than comparable rates for White Non Hispanics



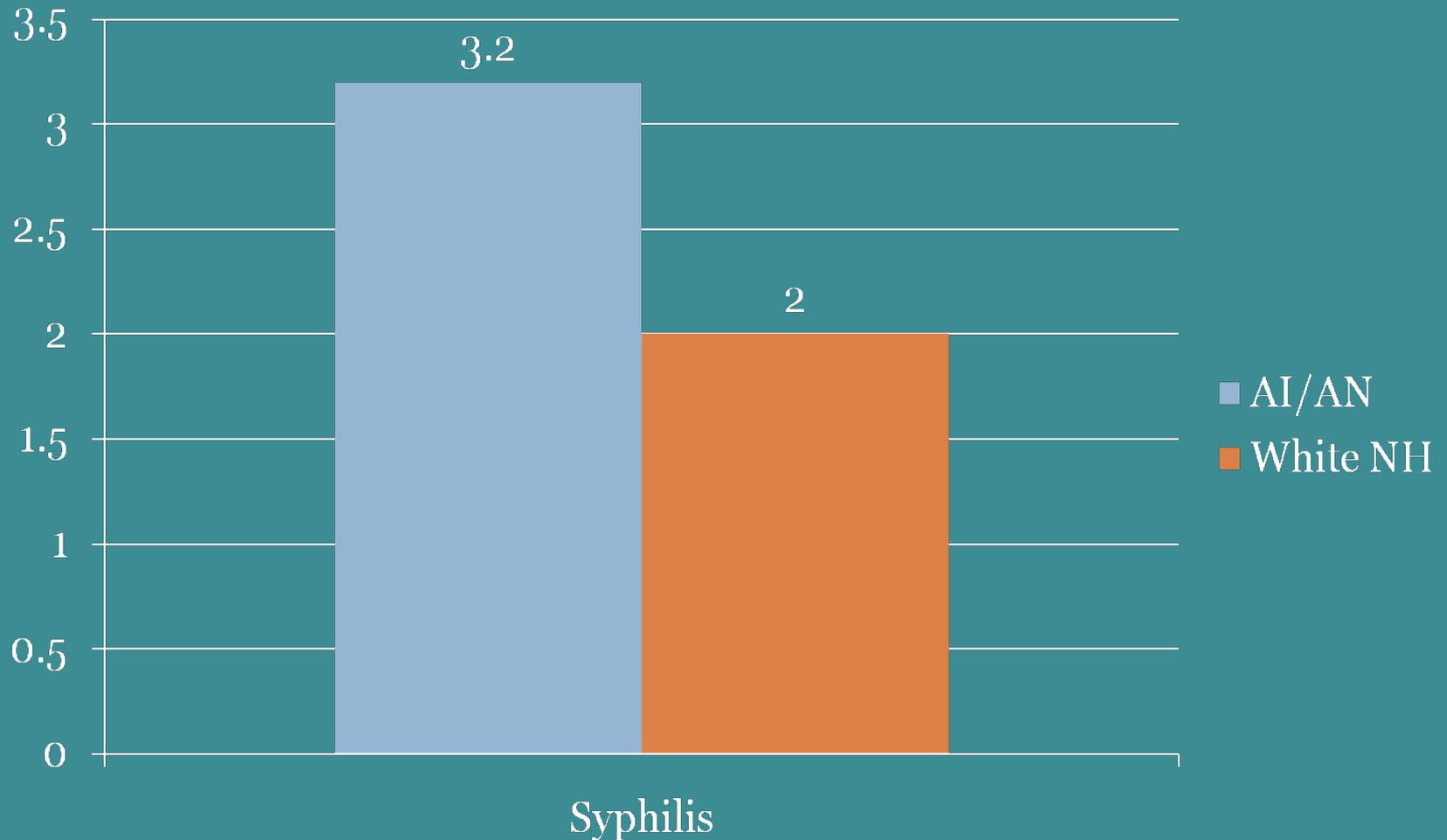
2007 AI/AN Chlamydia rates per IHS STD Rates – Chlamydia



2007 AI/AN Gonorrhea rates per 100,000



2007 AI/AN Secondary Syphilis (P&S) rates per 100,000



Substance Use

- Alcohol use and misuse
 - In 2002-2005, Natives more likely to have a past yr alcohol use disorder (10.7 v. 7.6)
- Drug use and misuse
 - In 2008, the rate of substance dependence or abuse for AI/ANs (12 yrs and older) was the highest at 11.1% v. 9% for whites
 - Increases in Natives using “meth”



Substance Use and HIV Transmission

- BOTH linked to high risk behaviors
 - Decreased inhibition
 - Alters perceptions
 - Interferes with body's use of vitamins/minerals used to maintain a health immune system
- Sexual contact among drug users
 - Multiple partners
 - Unprotected sex
 - Exchange sex for drugs
 - Needle sharing



Substance Use and HIV Transmission

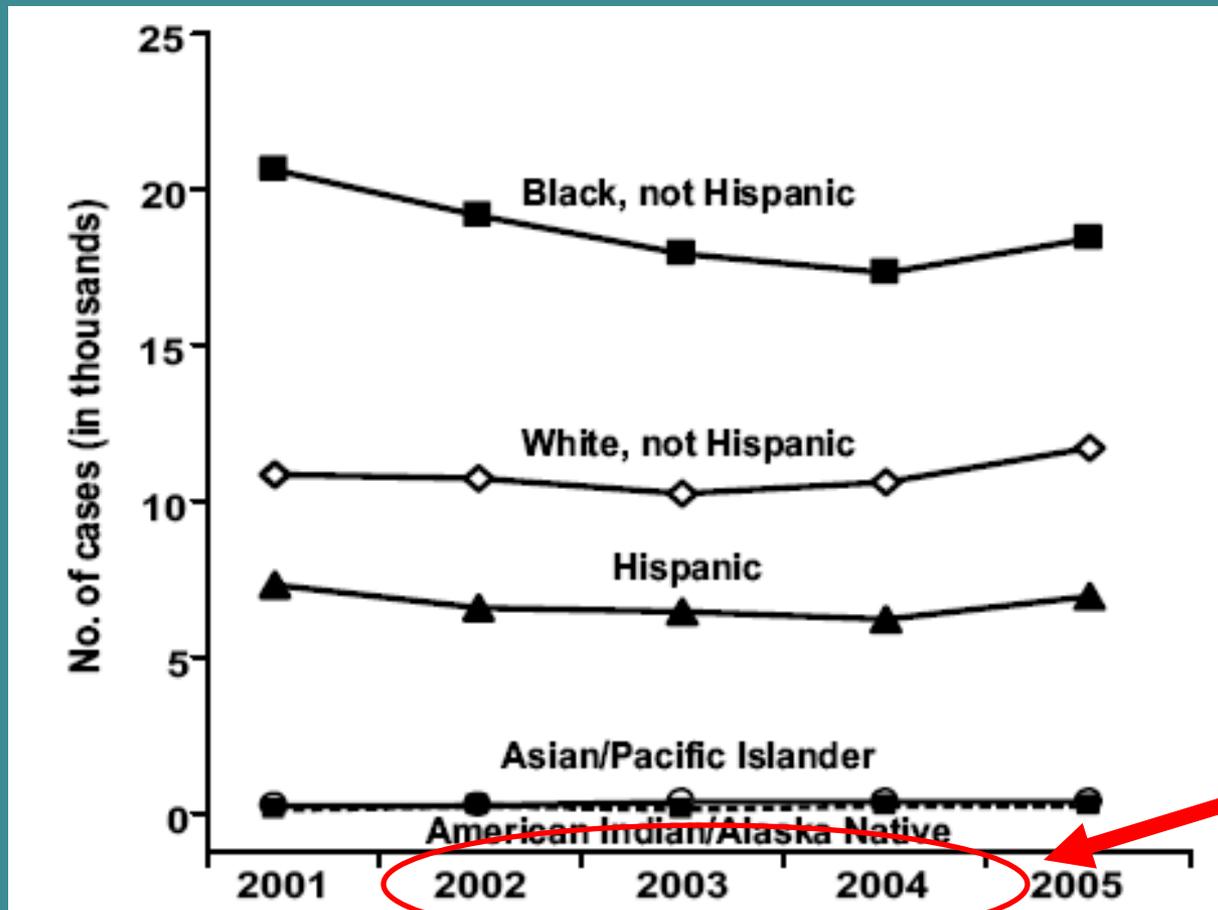
Adult/adolescents in 2007

- 16% of reported HIV infection cases among Native men involve injection drug use
- 33% of reported HIV infection cases among Native women involve injection drug use

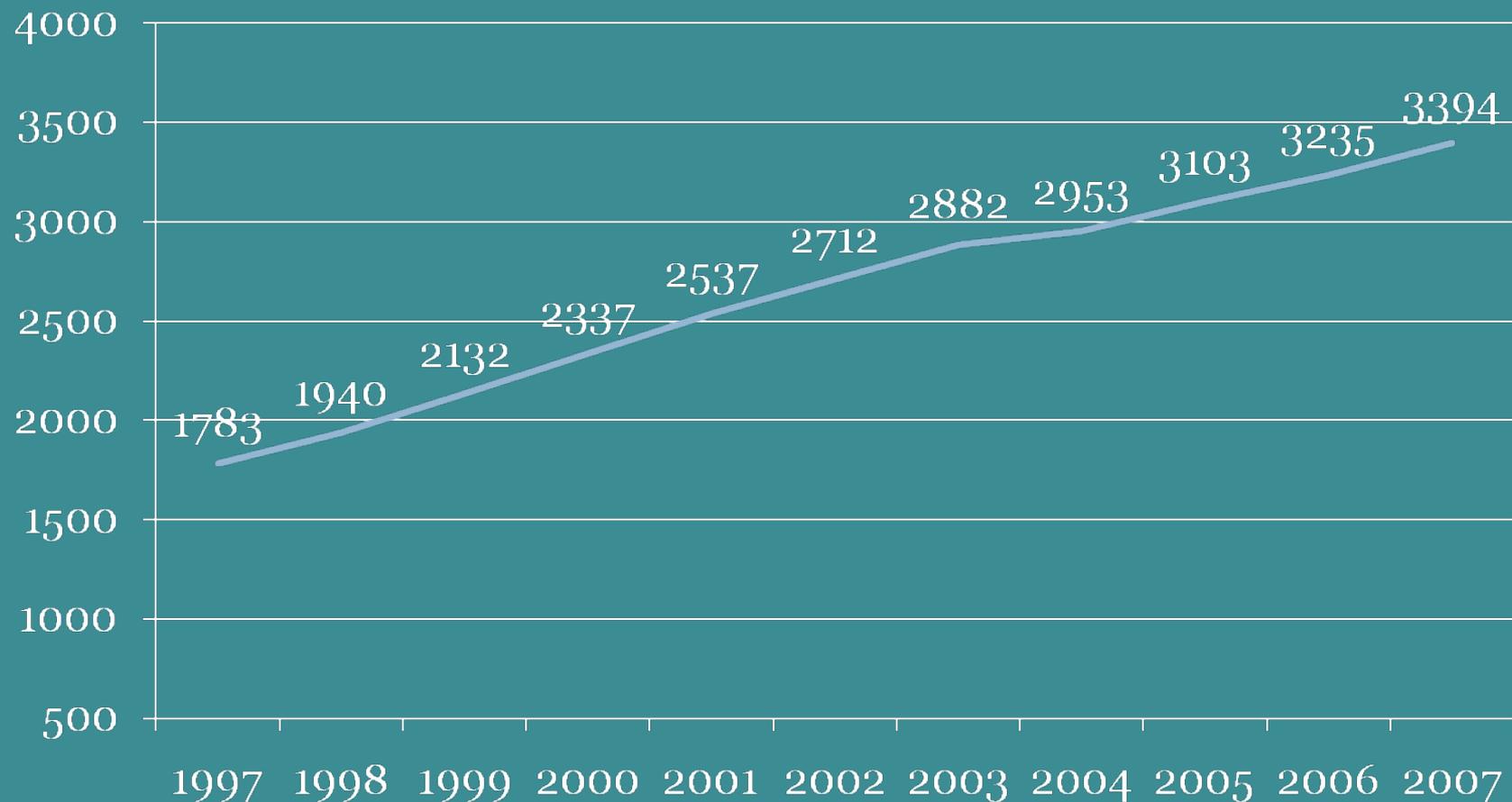


OUR CHALLENGE:

Cases of HIV/AIDS among persons 13 and above, by year of diagnosis and race/ethnicity, 2001–2005

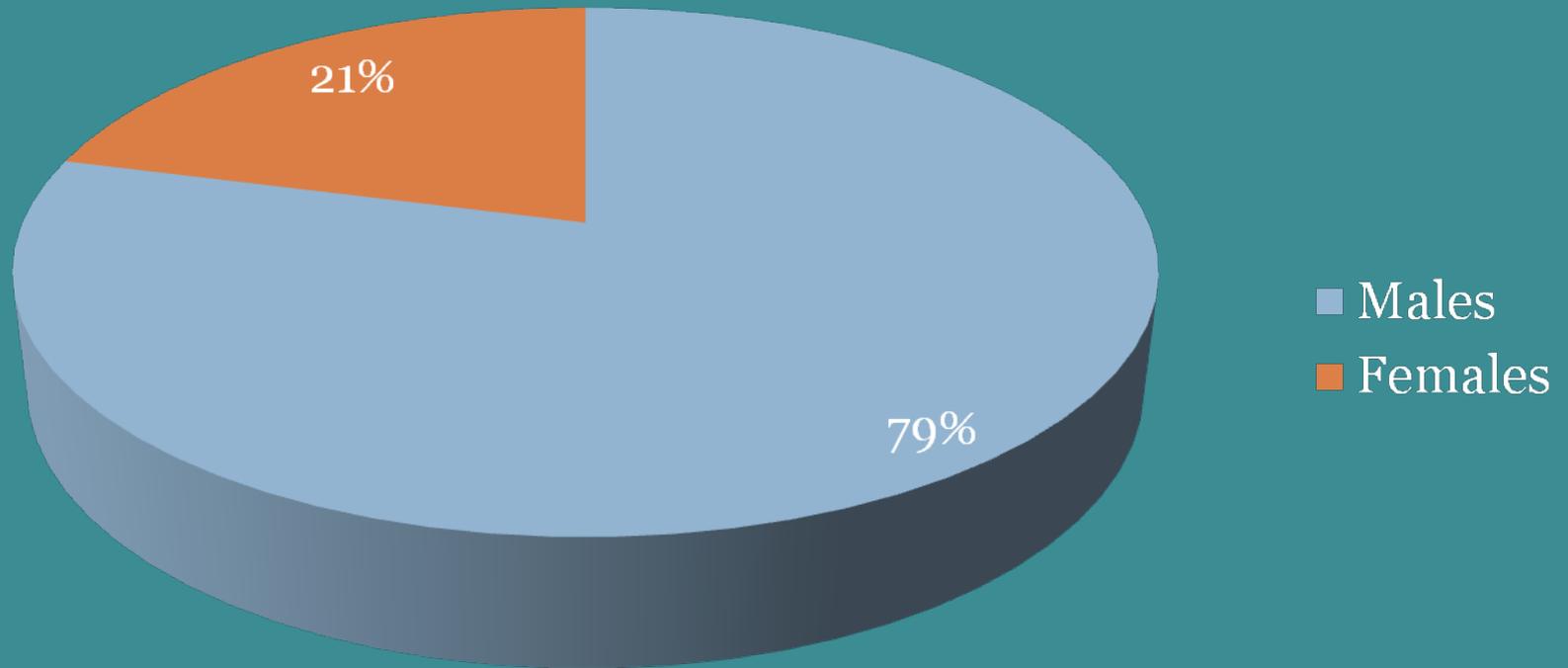


Growth in reported Native AIDS cases, 1997-2007

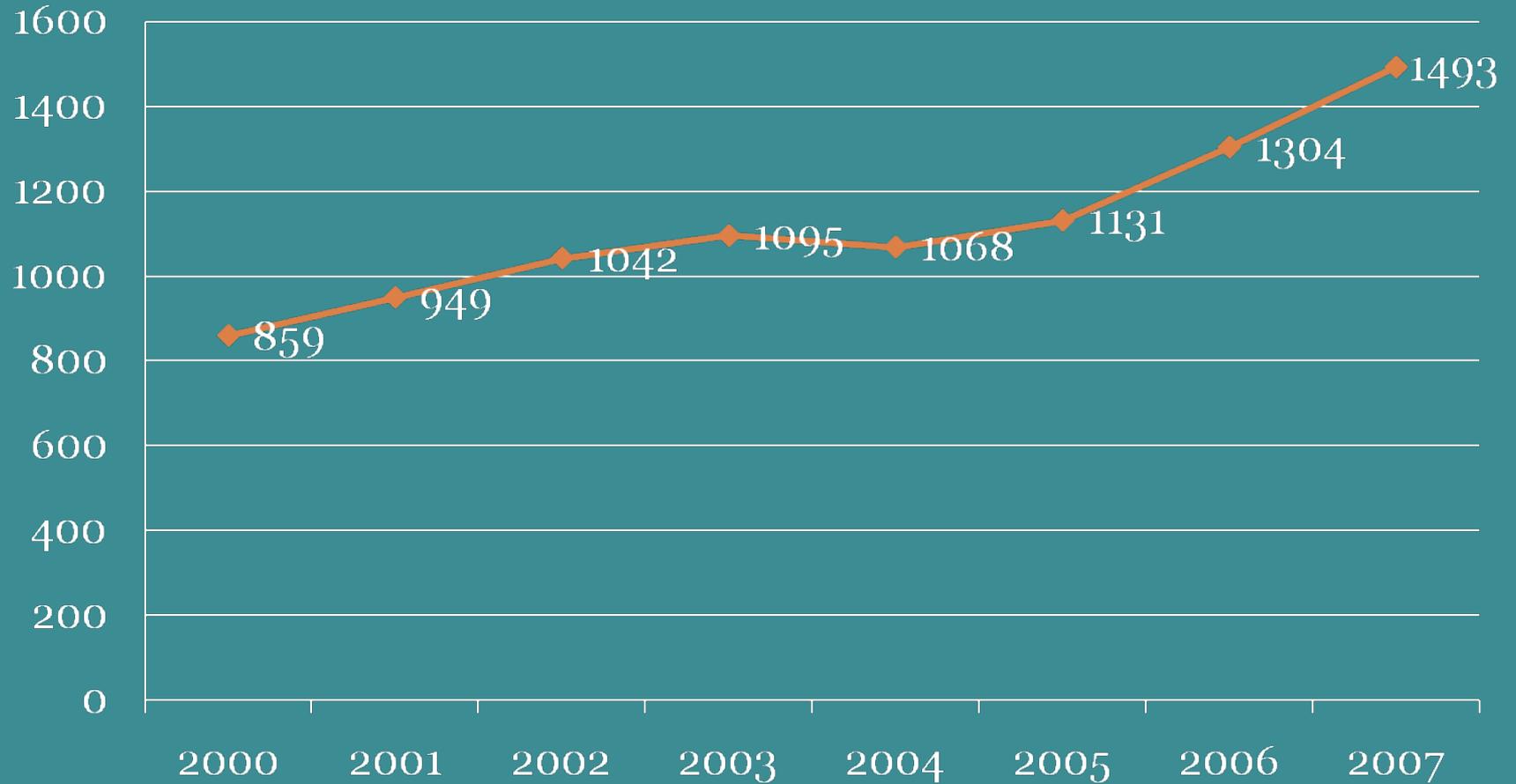


Cumulative Native reported AIDS cases, by gender, 2007

Adults and Adolescents

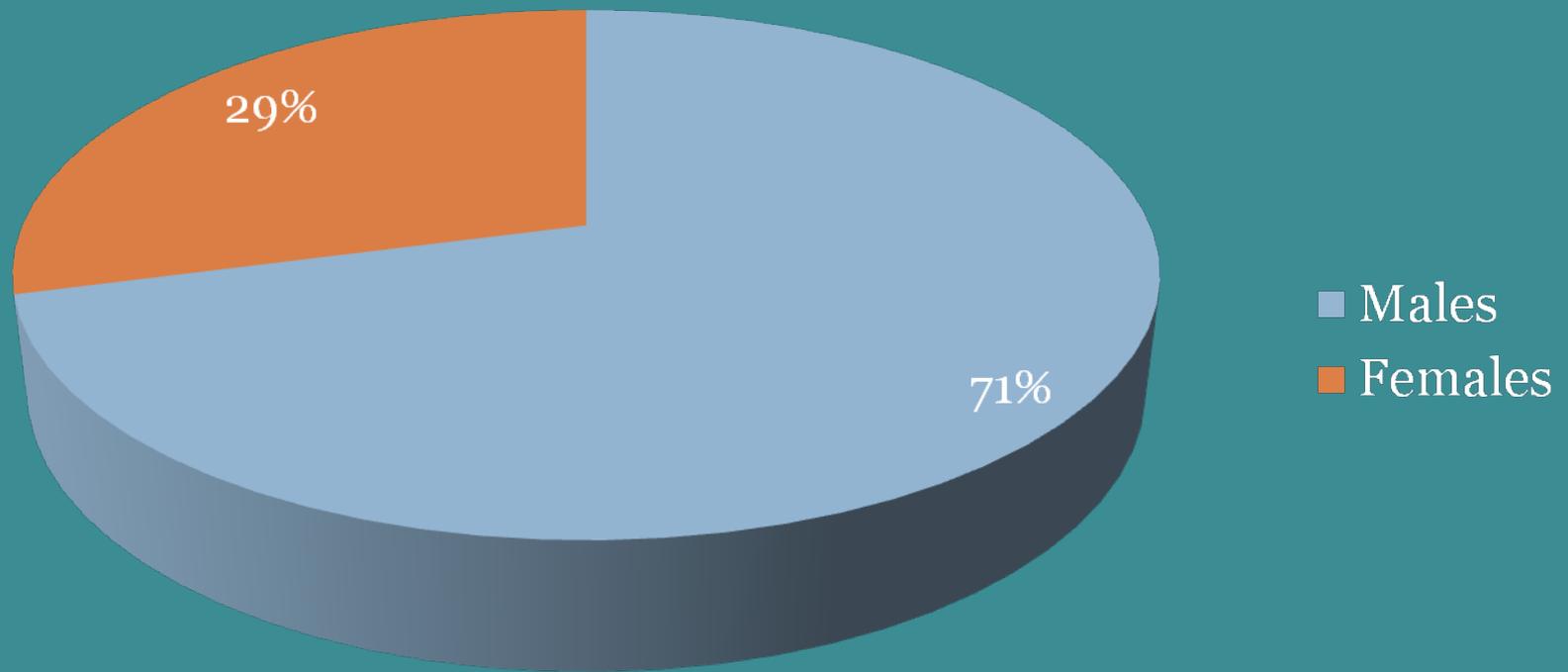


Growth in Native Reported HIV infection cumulative, adult/ adolescents, 2000 - 2007



Cumulative Native reported cases of HIV infection, by gender, 2007

Adults and Adolescents



Estimated rates (per 100,000) of HIV/AIDS of adults/adolescents by race/ethnicity, 2004-2007

	2004	2005	2006	2007
Black/African American	97.2	90.4	85.6	96.2
Native Hawaiian/Other Pacific Islander				43.4
Hispanic/Latino(a)	39.0	36.7	33.7	36.9
American Indian/Alaska Native	14.1	13.2	11.0	16.1
White	10.7	10.4	9.6	10.8
Asian	8.9	9.0	8.2	9.3

Small Numbers – Inaccurate Numbers

- Frequent racial misclassification
- Collection of Data
 - Gaps in coordination
 - Lack of trust
 - Poor Surveillance systems
- Natives not getting tested (confidentiality and mistrust)
- Natives classified as “other”



States Not
 Included in the
 CDC Surveillance
 Data for 22
 States.
 Red States are
 those with high
 Native
 Populations



States Without Surveillance	
State	Population of NA
Alaska	105,003
Arkansas	25,699
California	411,080
Delaware	4,392
District of Columbia	2,367
Hawaii	124,955
Idaho	22,857
Iowa	12,010
Kansas	28,021
Kentucky	12,808
Maine	7,899
Maryland	22,534
Massachusetts	19,494
Minnesota	62,645
Montana	61,916
Nebraska	19,618
Nevada	39,003
New Hampshire	3,947
New Mexico	192,483
North Dakota	35,923
Ohio	34,458
Oregon	35,061
Rhode Island	6,305
South Dakota	68,356
Utah	38,310
Vermont	2,485
West Virginia	3,629
Wisconsin	56,280
Wyoming	13,317
Total	1,472,855

States **not included in the CDC Surveillance for 33 States. Red states are those with high Native populations.**



States Without Surveillance	
State	Population of NA
California	411,080
Connecticut	14,005
Delaware	4,392
District of Columbia	2,367
Georgia	3,873
Hawaii	124,955
Illinois	38,705
Kentucky	12,808
Maine	7,899
Maryland	22,534
Massachusetts	19,494
Montana	61,916
New Hampshire	3,947
Oregon	35,061
Pennsylvania	24,897
Rhode Island	6,305
Texas	194,616
Vermont	2,485
Washington	111,337
Total	1,102,676

So what can
we do??



READINESS IS...

*The **first** essential step to making change!!!*



SO, WHAT IS COMMUNITY READINESS?

- An issue specific, community specific model of intervention
- Nine stage model designed to facilitate community-based change
- A clear structure for the prevention or intervention process
- A model that builds bridges between systems, peoples, and issues



Process for Using The Community Readiness Model

Identify Issue

➤ Define “Community”

➤ Conduct Key Respondents Interviews

➤ Score to Determine Readiness Level

➤ Develop Strategies/Conduct Workshops

➤ Community Change!



Who Uses Community Readiness?

- Any individual or group who wants to effect healthy
- change in a “community” or organization
 - ~ Concerned community members
 - ~ Community based organizations
 - ~ Administrators
- Researchers who want to compare communities
- Evaluators who need to assess progress pre and post
- Project Directors who want to increase the potential of effectiveness their strategies
- organizations who want to look at organizational or system readiness to deal with an issue



Successes of Community Readiness

- It's been used in over 1,000 communities throughout the United States
- It's been used Internationally as well as Nationally
- The manual is being translated into both Chinese and Spanish
- It's been used in the context of research, evaluation, and grass roots efforts
- It has been the focus of over 35 published articles in this country and others.
- Community Readiness received an award (\$\$\$) from the First Nations Behavioral Health Association as being one of the Ten Best Practices in Native Country.



5th National Native HIV/AIDS Awareness Day

**Our Networks Most
Successful Collaboration**

March 20, 2011



National Native HIV/AIDS Awareness Day (NNHAAD)

The National Native CBA Network was honored to be a part of the planning and development of the first National Native HIV/AIDS Awareness Day which took place on March 21, 2007. This day represents American Indians, Alaska Natives and Native Hawaiians!





National Native HIV/AIDS Resources

[HOME](#)

[ABOUT](#)

[NATIVE
HIV/AIDS
AWARENESS
DAY](#)

[TESTING
RESOURCES](#)

[EVENTS](#)

[LINKS](#)

[CONTACT](#)

Welcome

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Sed tortor justo, tincidunt vel feugiat nec, sagittis et lacus. Nunciaculis, metus vel rutrum tempus, eros dui facilisis ipsum, ut luctus augue libero sit amet erat. Nullam nulla odio, suscipit sed fermentum in, aliquam et dolor. Nam ac magna in diam aliquam hendrerit et non risus. Donec et erim ac nibh condimentum bibendum a vel eros. Etiam placerat viverra tincidunt. Pellentesque sagittis dolor et odio ultricies non suscipit purus rutrum. Suspendisse mollis porttitor neque vitae cursus. Pellentesque porta, metus vitae sollicitudin feugiat, neque augue cursus metus, non lacinia sem eros eget ipsum. Sed sed sem odio. Cras varius vestibulum ipsum, ut sollicitudin elit scelerisque sit amet. Pellentesque rutrum eros eu nisi tempor aliquet. Donec viverra accumsan sem, sit amet lobortis sem sodales at. Nam egestas lacus eu odio aliquet sollicitudin placerat mi porttitor. Duis vitae est tortor, eget luctus mi. Quisque interdum, diam in interdum sollicitudin, lorem tortor luctus nibh, ut ultrices metus nulla et elit. Etiam ac sem nisi. Class aptent tati sociosqu ad litora torquent per conubia nostra, per inceptos himenaeos. In accumsan consectetur mi, vitae congue sem feugiat id. Quisque mattis consequat leo vitae aliquet.

Sed ullamcorper elit vitae erim viverra eu commodo sem varius. Fusce eros lorem, aliquam non ullamcorper ut, molestie volutpat ligula. Phasellus pulvinar convallis tellus, condimentum adipiscing justo dignissim sit amet. Aenean tempor auctor imperdiet. Donec vehicula egestas erat at vehicula. Integer non feugiat justo. Phasellus mattis rutrum libero sed adipiscing. Duis vestibulum sem orci. Mauris posuere egestas pulvinar. Ut eu nulla leo, eu feugiat diam.



National Native HIV/AIDS Resources

HOME

ABOUT

NATIVE
HIV/AIDS
AWARENESS
DAY

TESTING
RESOURCES

EVENTS

LINKS

CONTACT

Service Provider Information: California

Listed below are resources for service providers in the state of California. Information included on this page include regional Indian Health Service providers, State Health Department (HD), Tribal clinics, Tribal Health Departments as well as urban health programs and non-profit organizations.

To update your information or to submit a request to include your program/organization, please email andrea.israel@cdostate.edu.

REGIONAL INDIAN HEALTH SERVICE PROVIDER

California Area Indian Health Services

650 Capitol Mall, Suite 7-100
Sacramento, CA 95814
Phone: (916) 930-3927
Fax: (916) 930-3952

STATE HEALTH DEPARTMENT

California Department of Public Health

Office of AIDS
PO Box 997426, MS 7700
Sacramento, CA 95899
Phone: (916) 449-5900
Fax: (916) 449-5909
<http://www.cdph.ca.gov/programs/aids/Pages/Default.aspx>

TRIBAL HD/CLINICS/URBAN/NON-PROFITS/OTHER

Cabazon Band of Mission Indians Clinic

84-245 Indo Springs Drive
Indio, CA 92203
Phone: (760) 342-2593
Fax: (760) 347-7880

Questions Comments



**Thank You for Sharing Your
Time!!**

www.happ.colostate.edu



Our BESAFE Products



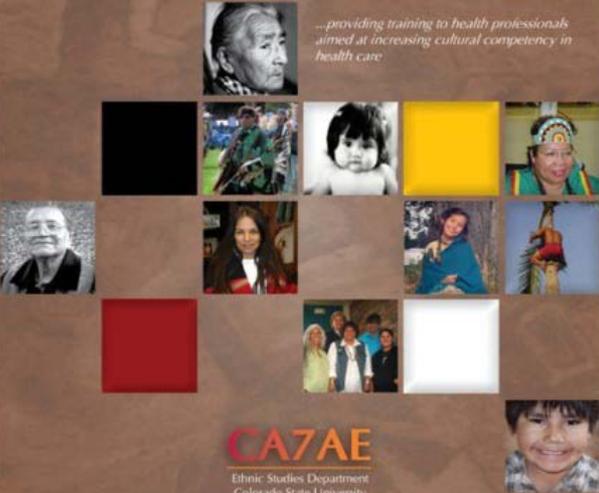
Our New BESAFE Poster Targeting Native People



BESAFE

Commitment to Action for 7th-Generation Awareness & Education (CA7AE):
HIV/AIDS Prevention Project

*...providing training to health professionals
aimed at increasing cultural competency in
health care*



CA7AE

Ethnic Studies Department
Colorado State University
357 Aylesworth Hall SE
Fort Collins, CO 80523-1790
Toll-Free (800) 642-0271
Fax (970) 491-2717
<http://besafe.colostate.edu>

A National Minority AIDS Education & Training Center
Regional Performance Site

Our New Fact Sheets for BESAFE

BESAFE Methamphetamine Use and HIV/AIDS in Native Communities

This contribution raises the chance of sex without condom use among both men who have sex with men (MSM) and the heterosexual population [1].

- The use of dirty or contaminated needles is also a common method of HIV transmission for injection drug users (IDU) [1].
- MSM use advances the progression of HIV to AIDS [1].
- Ultimately, "very abuse treatment is HIV prevention" [1].

BESAFE Methamphetamine Use and HIV/AIDS in Native Communities

American Indian, Alaska Native (AI/AN) and Native Hawaiian populations have, in recent years, seen the rising threat of methamphetamine use in their communities. What most don't realize is the extent to which meth use increases the risk of HIV infection.

What is Methamphetamine?

- Methamphetamine, also known as meth, speed, uph, ice, G, crystal or glass, is categorized as a stimulant because of its direct effect on the nervous system. Meth is comprised of everyday household products and over-the-counter medications, i.e., some decongestants [1].
- Depending on the ingredients and formula use, meth can range in color and form. Meth can come in a powder, a capsule, or in crystal form, and can be smoked, injected, snorted, or ingested.

The Spread of Meth

Scope and Impact of Meth Use:

- Compared to other stimulant groups in the United States, American Indian and Alaska Native (in some regions) experience higher rates of substance use disorders resulting in a need for 10 percent [2].
- In a survey across 36 states [3]:
 - 47% reported that meth was the biggest threat they faced.
 - 64% believed that meth use was responsible for an increase in domestic violence incidents.
 - 48% said child abuse and neglect cases had increased because of meth use.
- According to a SAMHSA study that included individuals ages 12 years and older, Alaska ranked first for the prevalence of meth use at 13.7%, compared to 9.8% for Blacks, 6.5% for Whites, 7.5% for Native Hawaiian/Other Pacific Islander and 6.5% for Hispanics [4].
- Meth use impacts all aspects of Native communities, both socially and individually. According to a survey conducted by the Title IX Sexual Harassment Investigator Support Center, high meth use in Indian Country has increased crime levels needed to protect victims, including sexual assault, neglect, and abuse [5].

Relationship between Meth use and HIV:

- Not only does meth appear to increase HIV, but it lowers inhibition

BESAFE HIV/AIDS Statistics for AI/AN/NH

Biological risks

- The prevalence of STDs in AI/AN communities is extremely high. Further, Natives are second for both the prevalence (130.3 per 100,000) and the incidence (2,262.2 per 100,000 persons) [6]. STDs are directly associated with transmission [6].

Substance Abuse

The use of substances such as alcohol and drugs (crack and cocaine) make the risk for HIV infection (especially high). Alcohol and drugs have serious behavioral reactions, but actually work as a disinfectant, which leads to high-risk sexual

BESAFE HIV/AIDS Statistics for AI/AN/NH

American Indian, Alaska Native (AI/AN) and Native Hawaiian populations have, in recent years, experienced high health care costs. This is very apparent when one considers the long incidence of HIV infections.

Estimated number of AIDS cases by race/ethnicity, 2006, Cumulative

For example:

- From the beginning of the epidemic through 2006, AIDS was diagnosed in an estimated 3,342 Alaska Natives [7].
- In 2006, Alaska had the 3rd highest HIV/AIDS diagnosis rate of 4.6 per 100,000 persons, compared to 3.0 for Blacks, 2.0 for Hispanics, 1.8 for Whites and 13.3 for Asian and Pacific Islanders [8].

American Indian/Alaska Native in Comparison

- At the end of 2006, Alaska had sustained for a shorter amount of time than Asian/Pacific Islanders, Whites, Blacks or Hispanics. As of 2005, only 17% of Alaska were diagnosed with HIV of Blacks, 8% of Hispanics, 67% of Whites, and 80% of Asian/Pacific Islanders [7].

Health professionals are now giving greater attention to HIV infection rates in an effort to form a more comprehensive and accurate picture of the epidemic to enhance and improve prevention and care services. Currently, surveillance reports reflect HIV infection and AIDS cases for Alaska based on a 50% while the rate for AI/AN Natives is 30% [7].

HIV/AIDS Among Native Hawaiians

- Native Hawaiians have been placed in the same category as "non-Pacific Islander" in much of the data released in the United States. Even though the Office of Management and Budget has mandated a category for Pacific Islanders, 1.5 million is not representative [9].
- According to surveillance reported during 2002 - 2007, in the state of Hawaii 3,211 individuals were reported to have AIDS and approximately 16.2% were Native born. Of the 3,211, 17% were reported as Hawaiian/Pacific Islander. Over the 5-year report the average rate of transmission for Hawaiian/Pacific Islanders is 0.2 per 100,000 [10].

Know the contributing factors

Socioeconomic Status

- The rate of AIDS is 60% to 80% higher than any other race/ethnicity group while Native Hawaiians and Other Pacific Islanders come in at 14% [10].

Methamphetamine Use & HIV/AIDS Fact Sheet

HIV/AIDS Statistics for AI/AN/NH Fact Sheet

BESAFE Cultural Competency Model

Sensitivity of the Provider addresses the need for providers to examine their own prejudices and biases through their culture and determine when they are using a continuum that ranges from unconscious to conscious competence. Sensitivity to:

- Education, stress, own biases and prejudices, race, ethnicity, sexual orientation, language, gender, age,
- Educational level, culture,
- Asset/cultural expectation

BESAFE Cultural Competency Model

CATAE offers free training on the BESAFE Cultural Competency Model

CATAE (BESAFE) Community of Action for 7th-Generation Awareness and Education (CATAE Education Project) at Colorado State University has established a collaborative relationship with NIMHC's Cultural Minority AIDS Education Training Center to provide training to health care providers using the BESAFE Cultural Competency Model. This training enhances the ability of health care providers to better understand how Native/Alaskan cultural factors can enhance the attitudes, behaviors and policies on health care provision.

The manner in which health care providers recognize and respond to this diversity is critical to the development of effective and culturally appropriate health care, prevention, and intervention programs. Often patients lack traditional cultural barriers when entering care and treatment for HIV and AIDS, making it vital that health care professionals acknowledge and utilize culturally sensitive care components when addressing the care and concerns of Pacific people. The training provided is a sensitive and caring manner and allows adequate time for discussion and questions.

Introduction to BESAFE:

The BESAFE framework is based on research conducted by Campagna-Bacote that uses culturally pluralistic content & perspectives based on the following 6 core elements to guide providers in caring for members of all races.

Barriers to Care: address real and perceived gaps in providing quality care and the impact of race and ethnicity on each of them. Barriers to Care include:

- Mismatch of medical systems, HIV programs
- Lack of access, no insurance
- Stigmatized, lack of awareness about HIV transmission
- Lack of support systems, poverty, crime, violence
- Stigmatizing, racism, homophobia

Ethics: addresses the morality of beliefs, values, and behavior. Providers must give priority to professional duty, valuing of different cultures, and issues apparent to honesty, confidentiality, death and dying as they relate to HIV/AIDS. Ethics, such as:

- Integrity, values
- Belief systems
- Professional ethics is "to do no harm"
- Confidentiality

BESAFE Cultural Competency Model Fact Sheet



